Using Section 1115 Waiver Authority to Implement Beneficiary Contribution Programs in Medicaid

Since the implementation of the Patient Protection and Affordable Care Act (ACA, P.L., 111-148, as amended) in 2014, eight states have expanded Medicaid programs under Section 1115 waiver authority, which allowed them to adopt alternative approaches to expanding Medicaid than that envisioned by the ACA. Six of these states adopted policy changes that mirror commercial benefit and enrollment design, including beneficiary contribution requirements such as premiums, which are typically linked to health savings-like accounts or incentives to complete certain healthy behavior activities.[1] An additional state, Kentucky, received approval from CMS to implement these policies. However, this approval was vacated by the U.S. District Court for the District of Columbia and remanded to the U.S. Department of Health and Human Services (HHS) for further review.[2] Five additional states—Kansas, Maine, North Carolina, Utah, and Wisconsin—have asked the Center for Medicare & Medicaid Services (CMS) for permission to implement similar approaches.[3]

States designed these waiver policies to increase beneficiary engagement in maintaining health coverage, seeking preventive care, and being cost conscious when making decisions about their health care. While states differ in their specific policy approaches and goals, they cite the following rationales:

- Imposing premiums and disenrollment or lock-out penalties for non-payment will increase beneficiary responsibility for maintaining health coverage and prepare them for a transition to private coverage.
- Health savings account programs are a tool to educate beneficiaries about the cost and appropriateness of their health care use and incentivize them to consider these factors when seeking care. For example, in Indiana, deductions are not taken from beneficiary accounts for preventive services and remaining balances can be used to reduce or eliminate future premiums.
- Healthy behavior incentives encourage beneficiaries to identify health risks and use preventive health services in order to constrain costs and improve health. For example, Michigan enrollees can reduce cost sharing requirements by completing a health risk assessment.

This brief provides an overview of these policies in six states: Arizona, Arkansas, Indiana, Iowa, Michigan, and Montana.[4,5] It describes each state's goals and program policies. For states with well-established programs, the brief discusses the activities and challenges associated with implementation as well as available results from required monitoring reports and interim evaluations.

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Features of Beneficiary Contribution Policies

While all six states use premiums, they use different combinations of incentives and penalties to encourage beneficiaries to continue making premium payments and seek preventive health services.

- Three states—Arkansas, Iowa, and Montana—require monthly premiums.[6]
- In three states –Arizona, Indiana, and Michigan – monthly premiums serve as contributions to a health savings-like account.[7]
- In Indiana, individuals with incomes over 100 percent FPL who do not pay premiums are disenrolled and cannot re-enroll in Medicaid for up to six months. In Arizona, Iowa, and Montana, individuals can be disenrolled but can reenroll at any time. In Arkansas and Michigan, individuals cannot be disenrolled but may continue to be liable to the state for unpaid premiums.
- In two states with premiums—Arizona and Indiana—individuals with incomes below 100 percent FPL can choose to pay either premiums or co-payments.
- In Arizona, Indiana, Iowa, and Michigan, enrollees can reduce premium payments by completing healthy behavior activities, such as a health risk assessment or preventive care visits. In Arizona, enrollees can also earn additional benefits through completion of healthy behaviors.
- All six waiver states require co-payments. In two states—Arizona and Michigan—co-payments are billed retrospectively, while in others they are collected at the point of service (Table 1).

TABLE 1. Features of Beneficiary Contribution Policies by State

State	Monthly contributions			Co-payments	Healthy behavior incentives
	Premiums	Accounts	Non-payment penalty		
Arizona	Serve as account contributions	Monthly contributions are the lesser of 2 percent of income or $25. Funds can be used for additional services.	Disenrollment for enrollees with incomes over 100 percent FPL; co-payments for enrollees with income below 100 percent FPL	Enrollees are subject to retrospective cost sharing for selected services (billed by quarter), except for enrollees with incomes under 100 percent FPL who opt into paying premiums	Beneficiaries who meet a healthy behavior target are temporarily exempt from premiums and co-payments. They can also use account funds for services not normally covered.
Arkansas	Beginning in 2017, premiums for enrollees with incomes over 100 percent FPL not to exceed 2 percent of income	Prior to December 2016, tiered contribution to account	Unpaid premiums can become debt to the state	Enrollees with income over 100 percent FPL are subject to co-payments consistent with normal Medicaid rules	None

TABLE 1. (continued)

State	Monthly contributions			Co-payments	Healthy behavior incentives
	Premiums	Accounts	Non-payment penalty		
Indiana	Serve as account contributions	Tiered contribution to accounts based on income (ranging from $1 to $20) plus 50 percent surcharge for enrollees who use tobacco products; accounts used for first $2,500 of claims for non-preventive services	Disenrollment and six-month lock-out for enrollees with income over 100 percent FPL; co-payments for enrollees with income below 100 percent FPL	Enrollees with income under 100 percent FPL who do not pay premiums are subject to co-payments; all enrollees subject to $8 co-payment for non-emergency use of the ED	Enrollees can reduce their required premiums by receiving certain preventive health services
Iowa	$5 for enrollees with income over 50 percent FPL; $10 for enrollees with income over 100 percent FPL	None	Disenrollment for individuals with income over 100 percent FPL; unpaid premiums become debt to the state	None	Premiums waived if beneficiaries complete a wellness exam and health risk assessment
Kentucky (approved by CMS but vacated by the U.S. District Court for the District of Columbia)	Premiums up to 4 percent of income	State-funded account used for first $1,000 of claims for non-preventive services; see healthy behavior incentives	Disenrollment and six-month lock-out period for enrollees with income over 100 percent FPL; co-payments for enrollees with income below 100 percent FPL	Enrollees with income under 100 percent FPL who do not pay premiums are subject to co-payments	All enrollees have a rewards account that accrues based on meeting healthy behavior targets and other state-defined activities, which can be used to purchase additional benefits
Michigan	Serve as account contributions	For individuals with income over 100 percent FPL, monthly contributions to the MI Health Account are 2 percent of income. Account balance at the end of Medicaid enrollment can be used to offset the cost of other types of health coverage.	Unpaid premiums and cost sharing can become debt to the state	Monthly billing through MI Health Account for co-payments for services during prior six months	Enrollees who complete a healthy behavior target receive a 50 percent reduction in cost sharing or monthly contributions, and if their income is below 100 percent FPL, they also receive $50 gift card.

TABLE 1. (continued)

State	Monthly contributions			Co-payments	Healthy behavior incentives
	Premiums	Accounts	Non-payment penalty		
Montana	Monthly premiums for enrollees with income over 50 percent FPL that are credited toward co-payments	None	Disenrollment for individuals with income over 100 percent FPL. Unpaid premiums can become debt to the state	Enrollees may be subject to co-payments if co-payment amounts exceed 2 percent of income	None

Notes. ED is emergency department. FPL is federal poverty level. Medically frail enrollees and pregnant women are not required to pay premiums. The Medicaid aggregate cap on out-of-pocket spending at 5 percent of income applies. Arkansas received approval to implement health savings accounts for all waiver enrollees and require contributions for all enrollees over 50 percent FPL. However, it only went into effect for enrollees over 100 percent FPL and was discontinued for all groups in 2016 due to high administrative costs and low participation. Prior to 2018, Indiana was testing graduated co-payments for non-emergency use of the ED (i.e., charging some enrollees $8 for the first non-emergency visit and $25 for subsequent visits), but discontinued this program in the latest waiver extension.

Source. MACPAC 2018 analysis of CMS 2018a, 2018b, and 2018c; CMS 2017a, 2017b, 2017c, 2017d, and 2017e; CMS 2016a and 2016b; CMS 2015; CMS 2014a and 2014b.

Waiver Implementation

States are at various stages of the implementation process. MACPAC gathered information on program implementation and outcomes for Arkansas, Indiana, Iowa, and Michigan, finding that policies were complex and resource intensive to administer. Engaging beneficiaries was challenging. However, states reported greater numbers of people covered and greater use of preventive services.[8]

Implementation activities

All four states devoted significant staff time or relied heavily on contractors to implement their waivers. These efforts required intensive communication and coordination efforts across different entities responsible for implementation, and set-up and maintenance of IT systems. For example, states designed systems for determining required contribution amounts, established procedures for communicating with beneficiaries about their responsibilities and options for paying or reducing them, and applying payments or healthy behavior credits to beneficiary accounts (Table 2).

TABLE 2. Implementation Steps for Beneficiary Contribution Programs

Implementation activities
Enrollee contribution requirements
• Establish systems and processes to determine enrollees' required contribution based on their income level and—in Michigan—service use • Design invoice statements to convey premium requirements and other program features to beneficiaries • Collect and reconcile payments with enrollee accounts • Set up processes to take appropriate action when enrollees do not pay their premiums
Health savings accounts
• Set up procedures for communicating with and educating beneficiaries on their responsibilities regarding the accounts • Establish ways for beneficiaries to view their account balances (e.g., through account statements, web or mobile application portals) • Establish a process for reconciling information about beneficiary information, contributions, and completion of healthy behaviors, etc. between the state and its vendors, including MCOs
Healthy behavior incentives
• Establish a process for beneficiaries to complete a health risk assessment tool • Provide outreach and education to beneficiaries about healthy behaviors • Set up procedures for tracking healthy behaviors and participation in qualifying activities • Institute reconciliation processes to account for qualifying preventive services, healthy behaviors, and resulting account balances • Provide incentives to beneficiaries for the completion of a healthy behavior • Monitor health plans (in Indiana and Michigan) to ensure account reductions are applied appropriately when someone has earned a healthy behavior

Source. Zylla et al. 2018.

Implementation challenges

States faced a variety of challenges in implementing their waivers, including those related to basic set-up of IT systems, strategies for communicating with enrollees, procedures for coordinating between plans and the state Medicaid agency, and complexity of the waiver policies. Overall, states with a history of using similar policies in their Medicaid programs or that had longstanding relationships with MCOs and other entities responsible for implementation experienced fewer, less complex challenges than states starting from scratch. Examples of specific challenges states faced included:

- **Calculating and collecting premiums.** Iowa and Michigan—states that were not using widespread premiums in their Medicaid program prior to waiver implementation—experienced technical challenges collecting and applying premium payments. Indiana's managed care plans already had this capabilitybut had to regularly recalculate beneficiary premiums of 2 percent income due to even small changes in income. Indiana switched to a tiered premium structure to alleviate this burden on plans and beneficiaries.
- **Establishing and attracting members to health savings accounts.** Arkansas spent $9 million to set up and operate IT systems for its health savings account feature but was unable to attract significant

participation; only 7,000 to 8,000 Medicaid enrollees participated out of 40,000 who were eligible. Costs per enrollee became so high that the state terminated the program. Indiana, which already had a health savings-like account in place for Medicaid enrollees, built on existing systems and strategies for encouraging participation.

- **Crediting beneficiaries for healthy behavior activities.** Iowa and Indiana experienced technical and operational difficulties with reconciling claims systems and those used to credit beneficiaries for adopting healthy behaviors. Michigan, which uses paper-based health risk assessments, initially experienced a backlog of health risk assessments because doctors had difficulty identifying which plan to send them to (Zylla et al. 2018).

All states and health plans struggled with educating beneficiaries about their responsibilities and incentives under the policies and engaging them to participate. They noted challenges in conveying the concepts of premiums, account contributions, and cost-sharing to beneficiaries, especially how these concepts related to one another – for example, that enrollees could reduce their monthly contributions by completing healthy behavior activities (Zylla et al. 2018). These challenges are reflected in the evaluation findings, which indicate limited understanding of many of the complex program features from the beneficiary perspective. For more details on expansion waiver implementation and implementation challenges, see MACPAC's contractor report, *Section 1115 Medicaid Expansion Waivers: Implementation Experiences*.

Program Outcomes

Results of the expansion waiver programs with consumer engagement initiatives are limited, and formal evaluations are available only for Indiana, Iowa, and Michigan. However, a large body of research on the effect of premiums and cost sharing indicates that premiums lead to decreased enrollment, and that broadly applied cost sharing leads people to reduce use of both effective and less effective services. Thus far, no study has demonstrated a level of cost sharing that encourages prudent use of services without impeding access to necessary care (Artiga et al. 2017, MACPAC 2015). Research also has shown that state savings from premiums and cost sharing are limited (Zylla et al. 2018, Artiga et al. 2017).

Findings from state evaluations focused on the relationship between the premiums and cost sharing structure to beneficiary plan choices, health care use, and engagement with health savings-like accounts. They also looked at affordability and other barriers beneficiaries face in making premium payments. Overall, waiver enrollees generally reported being able to afford premiums and cost sharing and that they received high levels of preventive services. While they understood premiums and the consequences of not making payments, they were less aware of more complex features such as healthy behavior incentives, health savings accounts, and how the different features interact.

In addition to state-based evaluations, CMS initiated a multi-state evaluation to look at the effects of enrollee contribution programs (among other waiver program features) across states. While no findings are available currently, the interim evaluation plans to examine the extent to which required monthly premiums affect enrollment patterns, including continuity of coverage; the strategies states are using to educate beneficiaries about healthy behaviors incentives; the effect of healthy behavior incentives on

access to and use of care; and population-level effects such as preventive service receipt and smoking cessation (Colby et al. 2017).

Premiums

State evaluations, annual and quarterly reports, and other studies for Indiana, Iowa, and Michigan examined the extent to which beneficiaries have been disenrolled or locked out of coverage for non-payment.

- In its first demonstration year, February 2015 through January 2016, Indiana disenrolled 4,486 people with incomes over 100 percent FPL due to non-payment of premiums, or 6.3 percent of HIP 2.0 members in this income group. This number has grown in subsequent demonstration years, with the state disenrolling about 12,000 individuals with income over 100 percent FPL in each year, or about 20 percent of HIP 2.0 members in this income group (Indiana FSSA 2018). Between February 2015 and November 2016, an additional 46,176 people were determined eligible for coverage but never enrolled because they did not make their initial premium payments (The Lewin Group 2017).
- In Iowa, between 500 and 1,200 members per month with incomes over 100 percent FPL were disenrolled for failure to pay premiums in the first three quarters of 2017 (IDHS 2016a, 2016b, and 2016c).
- In Michigan, 186,162 beneficiaries had past due premium contributions or co-payments as of August 2017, and 76,552 of them were categorized as consistently failing to pay and their debts were recoverable by the state (MDHHS 2018).[9]

Some studies have also examined the reasons why beneficiaries fail to make premium payments. Most beneficiaries in Iowa and Indiana reported being aware that they could be disenrolled for non-payment. Most beneficiaries in all three states reported feeling that their contribution requirements are fair, and many feel they are affordable. However, affordability was consistently the most common reason for non-payment. For example, a survey of beneficiaries in Indiana found that among those who reported not making regular premium payments, 31 percent cited affordability (Sommers et al. 2018). Additionally, in interviews of, disenrolled members in Iowa, most individuals reported affordability as the primary reason they did not pay, and only one respondent knew that premiums could be waived for reaching of healthy behavior targets (Askelson et al. 2017).

Beneficiaries also experienced non-financial barriers to payment. Stakeholders in Michigan have cited members' inability to make payments by credit card and noted that that the cost of a money order to pay balances is often greater than the balances themselves (Musumeci et al. 2017). Additionally, confusion about how premium payments tie to health savings accounts presented a barrier in Indiana —about 20 percent of HIP-eligible survey respondents reported not paying premiums because they were confused about POWER accounts. Confusion was highest among individuals who identified as Latino or as having less education (Sommers et al. 2018).

Health savings accounts

State evaluations and studies of health savings accounts examined the extent to which beneficiaries understand and manage their accounts. While many beneficiaries knew they had accounts, they had mixed awareness of how the accounts work, and were not necessarily connecting them with behavior change.

- In Indiana, 60 percent of waiver enrollees reported having heard of a POWER account; of those, about 75 percent reported having one. Of members who reported having an account, only about 40 percent reported checking the balance regularly. About half (52 percent) incorrectly believed that the cost of preventive services was deducted from the account (The Lewin Group 2016b). However, a later survey of HIP 2.0 beneficiaries found that of those who reported being familiar with POWER accounts, about 60 percent agreed that the accounts helped them think about proper service use (Sommers et al. 2018).
- In Michigan, 75 percent of respondents reported receiving an MI Health account statement; less than half reported changing decisions about health care use based on this information (Goold et al. 2016).

Healthy behavior incentives

Interim evaluations in Indiana and Iowa and beneficiary surveys in Michigan looked at beneficiary knowledge of and engagement with healthy behavior incentive programs, and the effect of incentives on outcomes and beneficiary choices about service use. Additionally, quarterly and annual reports from each state show the healthy behavior incentive completion rates among beneficiaries.

- In 2017, Indiana's health plans reported that between 34 and 50 percent of HIP 2.0 members received preventive examinations qualifying for a healthy behavior incentive—an increase over the previous year, but below Indiana's goal of 85 percent (Indiana FSSA 2018). Only about half of HIP 2.0 members were able to correctly explain how receiving preventive services would allow them to roll over any remaining funds in their POWER account at the end of the year and reduce their required premiums (The Lewin Group 2016b).
- In Iowa, the highest participation rate for healthy behavior activities was 25 percent (Askelson et al. 2016).[10] In 2014, rates did not exceed 17 percent; lack of knowledge among members and clinic staff hindered progress toward program goals and led to members being disenrolled unnecessarily for non-payment of premiums (Askelson et al. 2017).
- In Michigan, as of December 2017, 18 percent of members enrolled for at least six months completed the health risk assessment process and were eligible to receive a healthy behavior incentive credit (MDHHS 2017).

Evaluations showed high use of preventive services (including those that qualify for healthy behavior incentives), but it was not clear that behavior was motivated by the incentive program given low awareness and understanding of the program. For example, a U.S. Government Accountability Office report noted that this lack of knowledge made it difficult to evaluate these programs' ability to change behavior (GAO 2018). Additionally, federal evaluators noted that because health plans often offer additional incentives for healthy behaviors that are separate from the demonstration, it is difficult to isolate the effect of the demonstration itself (Colby et al. 2017). For further details on other healthy

behavior incentives in Medicaid and their outcomes, see the MACPAC issue brief, *The Use of Healthy Behaviors in Medicaid*.

Endnotes

[1] Waivers often include other changes, such as the elimination of retroactive eligibility and coverage of certain benefits, requirements for work and community engagement participation as a condition of eligibility, and the use of premium assistance. However, these issues are beyond the scope of this brief.

[2] *Stewart et al. v. Azar et al.,* 1:18-CV-00152 (U.S. District Court for the District of Columbia 2018).

[3] Kansas would establish an optional health savings-like account for transitional medical assistance (TMA) beneficiaries, available to members for certain services or items after they transition out of the TMA program. Maine would implement tiered income-based premiums for members with incomes over 50 percent FPL. Utah would implement graduated co-payments for non-emergency use of the emergency department. North Carolina would implement premiums of 2 percent of income for enrollees with incomes over 50 percent FPL, but only if the state opted to expand Medicaid to the new adult group. Wisconsin would implement premiums for enrollees with incomes over 50 percent FPL, and enrollees could reduce their required premium by completing healthy behavior incentives.

[4] While New Hampshire expanded Medicaid through a Section 1115 waiver, it did not use this authority to implement beneficiary contributions or related policies.

[5]This brief does not discuss the features of Kentucky's waiver as approved provisions. For more detail on Kentucky's waiver provisions as approved by CMS, see MACPAC's fact sheet on the Kentucky Medicaid expansion waiver.

[6] Even without a waiver, states can require certain groups of Medicaid enrollees to pay enrollment fees, premiums, copayments, or other cost sharing amounts. However, federal guidelines generally do not allow states to charge premiums for enrollees with incomes at or below 150 percent FPL and total cost sharing (including premiums and per-service charges) is subject to an aggregate limit of 5 percent of family income (42 CFR 447.50–447.56).

[7] Arkansas also used this approach initially but terminated its health savings account program because of low participation and high administrative costs (Zylla et al. 2018).

[8] We advise caution in interpreting these early evaluation results from expansion waiver programs. Limitations include the early stage of implementation, methodological challenges typically associated with health services research, and insufficient data. Because most states with such waivers were not previously covering the new adult group, there is no appropriate comparison group to assess access, outcomes, affordability, or health care use. It is also difficult to attribute changes to the waivers themselves as many results are due to expansion of coverage itself rather than specific design features of the expansion program. In addition, multiple other initiatives were underway at the plan, state, and federal level (Sommers et al. 2016a and 2016b).

[9] In Michigan, this means that beneficiaries' premiums and cost sharing obligations were unpaid for three consecutive months.

[10] Exact rates varied based on the data source (ranging from 6.6 percent of Wellness Plan and 1.3 percent of Marketplace Choice enrollees as reported in the claims data to 25 percent of Wellness Plan and 12 percent of Marketplace Choice enrollees as reported by the Iowa Department of Human Services).

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